Skilled Nursing Facility Primer - Part 2

Recorded April 14, 2020

Presenter: Kathleen Dwyer, OTR/L, CHT

OccupationalTherapy.com Course #4708

- [Fawn] Today's course is skilled nursing facility primer part two. Our presenter today is Kathleen Dwyer. She is an occupational therapist with over 20 years of experience in the healthcare industry which includes professional leadership in the corporate setting. Following her graduation from Eastern Michigan University, she focused on earning her certification in hand therapy and also specialized in aquatic therapy. Her experience in therapy management began as the director of rehabilitation for a vast campus which included a skilled nursing facility, a long term acute care hospital, and an outpatient therapy center. Kathleen has also served as the Director of Operations for a chain of 56 skilled nursing facilities. She is certified in health care compliance and has also earned the RAC-CT which designates her as an expert in skilled nursing facility prospective payment system and the minimum data set assessment. She's currently working as the Executive Vice President for JMD Healthcare Solutions. Welcome back, Kathleen so happy.

- [Kathleen] Thanks Fawn, and appreciate you having me back, as well as everyone joining us today. So, let's just dive right in. As I would like to first go over my disclosures. So, there they are. And today's goals, so I'm really glad that we were able to separate this into two parts. And today's really more focused in on how you apply your learning from part one into your documentation and making sure that we are ready to go from a treatment perspective, so our goals for today are for you to be able to apply improved therapy documentation to clearly define appropriate goals and to list the items needed for our ready to go toolkit, all for working within a skilled nursing facility. And as I will shorten that into the term SNIF throughout this presentation as I did in the last presentation. So quick review from part one, if you were there with us, you learned quite a bit about the expectations of skilled care defined by the Centers for Medicare and Medicaid Services, also known as CMS. So in order for our services to be considered skilled, first of all, they need to be reasonable and necessary, they need to be consistent with the illness or injury, and they need to be delivered in an

appropriate duration and quantity. Finally, our services should be promoting the patient's therapeutic goals.

So today, we will take these lessons learned and apply it to our documentation to be sure that they are in fact skilled. The information that I'll be presenting today, primarily comes from chapter eight of the Medicare benefit policy manual. So we, in the course of part one, we talked a lot about different payers, and someone even asked about what are the expectations of other payers, so I just wanna add that Medicare is typically the most strict when it comes to guidelines and expectations. So, today's presentation, as the first one, is all about Medicare, but just so you know that typically Medicare gives us the most strict guidelines as far as making sure our documentation reflects that skilled care. I've had a lot of therapists over the years ask me the question, just tell me what to write, tell me what to write so that my services won't be denied. And I think that that's a valid question, because you might have worked for a lot of different facilities or different levels of care and the expectations are different. So what we're gonna review today is what I wanna consider best practices moving forward and using chapter eight as our guideline.

I really wanna give you some tips throughout the today's presentation to make sure that you understand words and theories that you can put into your documentation that really will help it define your skilled services. I noticed in our polls today that we have quite a few registered occupational therapists and I'm glad because we're going to start with evaluations, but for the assistants who are on, don't tune out, because I think it's important for you to also know what are the expectations for the evaluations. So first of all, I'm gonna say this a lot today, we need to be painting the picture of our patients in front of us. Everything that we write down, whether it's in our vals, our progress notes, our daily notes, all has the likelihood of someday being reviewed by somebody else. And sometimes that review happens years later, and it's our responsibility as therapists to make sure we're painting that picture so that anyone who

reads our documentation, whether that's an auditor, another therapist, maybe perhaps a non skilled case reviewer, all of these people need to be understanding how the services that we provided are skilled and how are they meeting those requirements.

So let's paint the picture through the evaluation. First of all, it must describe the medical history. So, we need to set the stage for why this patient is requiring our skilled services. It's important that in our medical history we're including those comorbidities, because obviously those are going to impact how we approach the patient. But we also need to be talking about that reason for skilled care. So typically, the diagnosis gives some background of proof that they do require the skilled nursing level of care. And typically, not always, but typically the diagnosis that we're bringing forward in our documentation is what they were also treated for in the hospital. It might not always be the case, but that is what's typical. But we wanna make sure that our diagnosis is supporting that they need skilled care. It's also important that our documentation includes any pertinent characteristics that are gonna impact how we provide our care. So examples of this would be if the patient is hard of hearing, or if the patient presents with a cognitive deficit, because we would obviously be changing our approach to how we care for them. And it should be documented so that as our plan of care gets transitioned to different assistants or different treating therapists, that we all are well aware of any of those pertinent characteristics. Obviously, precautions and contraindications are extremely important for the same reason.

And also, we should be painting the picture of the patient's prior level of function. So what was this patient able to do prior to the onset of this disease or illness or condition. And if the patient is unable to tell you what their prior level of function is, it's really important that we do try to gather this information. So whether that's looking deeper into the medical record, or perhaps even calling a family member. Prior level of function really is setting that stage, so that we can then prove that what we're working on is to really get them back to that level of function. Also just a little key here about

evaluation codes, they are untimed, so always billable as one unit. And if you are, as the occupational therapist, providing any treatment on that day, or if you pass the patient and the CODA provides treatment on that day, that treatment has to be, first of all, billed using the CPT codes that are appropriate for that treatment, as well as documented, so don't forget that. So goals should be set so that they are reasonable for this individual patient.

So as the evaluating occupational therapist, we are responsible to check that these goals continue to be appropriate as the patient progresses in our plan of care. And if at any point during the planned care it becomes apparent that the goal is no longer reasonable, then it is our responsibility to modify that goal, and make sure that the treatment approaches that are changed to reflect that modification. We also should be reassessing our patients. If the needs change, perhaps the discharge plan changes, then that would be another time for us to be involved as the occupational therapists to reassess, and also to make sure that they still require the provision of skilled services. Particularly important in the skilled nursing setting, is that our goals should relate to function and be meaningful to our patients. I

'm gonna give you a couple of examples here. Three points that I feel are just very important components to writing goals, they should be patient centered, they should include a functional component, and they should have a measurement element. So I've given us three examples that I wrote. Very simple, patient will complete upper body dressing with minimal assist. Patient will complete ADL while standing at the sink side with contact guard assist for balance. Patient will increase upper extremity strength to five out of five in order to assist with functional transfers. That goal should be written so that we're focusing in on that next level of care and reminder, back to part one, we're always trying to assess them for what would be the lowest level that they would need at that next level of care. Our goal should be set, as I've said already, that are

reasonable, but that are also achievable for each patient. And as I also did say earlier, we should be updating them if they are no longer appropriate.

So there's several areas that in a skilled nursing facility that OTs are involved with. And I know this is a very broad spectrum here. So, just to touch base on a few of them, we obviously can be working on our activities of daily living. That would include dressing, bathing, grooming, eating, toileting. And remember, you can then write your goals for specific areas of toileting. You could break it down into parts of hygiene, clothing, management, and transfers. So on the transfers note. We just wanna make sure that as the occupational therapists, we're keeping our transfer goals within our ADL wheelhouse. So we wanna make sure that we're focused on function. So toilet transfers, tub transfers, bed to chair transfers. This is important because we wanna make sure that we're not duplicating with physical therapy. Medicare is not gonna cover services that are a duplication. So it is important that we communicate with our counterparts so whether that's PT or OT, in this particular example we're talking about transfers, so coordinating with that PT, making sure we understand what they are working on, what their goals are, what their interventions are going to be, so that our goals can be on something different. So, same with balance. I mean, obviously PT can have their goals for balance and so can we, we just wanna make sure that we're not duplicating. So writing our goals focused on ADLs sitting balance, while dressing upper body. Standing balance, while dawning lower extremity. These are important areas that you really focus to function on. And same with strengthening just to mention that as well. Let's keep it tied to function. So what will this patient do better, or will be aided with increased strength. So keep in mind, like I said in the example earlier, we're increasing upper body strength to aid this person's ability to do transfers.

I also think that IADLs, instrumental activities of daily living, are very important in the skilled nursing facility, especially with the home going patients, or even if they're going to an assisted living, independent living. These are important areas to address. So can

we address their laundry, or simple meal prep, item retrieval, functional mobility. Maybe we would just write a goal for using their walker safely in the kitchen. Perhaps, carrying items in the kitchen. Just keep it focused on our activities of daily living. And I promise you, your goals will be appropriate.

Motion treatment is another area that as occupational therapists, we need to be very specific for the patient's individual needs. So in the skilled nursing setting, we do see mostly individual treatment, but what the recent changes of PDPM, the new payment model, group and concurrent now have become a little bit more used again which is great, so let's talk it through. Let's start with the individual mode of treatment. This is obviously a one to one ratio of the patient to the therapist. And CMS did release this statement that's on the slide. This was actually released right around the time that the payment models switched to PDPM. So I think it's important that we do remember that per CMS, the preferred mode of therapy provision should be considered standard of care in therapy services as the individual treatment. So it is still our number one mode of treatment that should be used. They do also state that if you are having any safety concerns with a patient that your treatment should be individual. The next mode of treatment is concurrent. And this is defined as when a patient is provided therapy along with another patient. So one therapist treating two patients. What makes this different from group, is that concurrent treatments are with activities that are done different. So this is a little bit more challenging because you're having two patients training at the same time, who are performing different activities. So in order for this to be considered skilled, we have to make sure that it's goal centered. So this means that as you provide different activities to two patients, they both must be working towards their individual goals. Also, just like everything else we've said, we need to make sure that this task or activity is meeting skilled criteria and must be medically necessary.

And concurrent therapy may only be a portion of an intervention, which means you might do concurrent for a part of your session and that that's definitely fine and it is

acceptable as far as Medicare is concerned. AOTA did release some resources on concurrent therapy in late 2019 to help with the transition to PDPM. And in those resources, they indicated that concurrent therapy should be used the least often, as far as our modes of treatment for OT. And I think that's just because it is very challenging to have two treatment sessions side by side, working on different goals and activities. I also wanna add that, according to Medicare Part B, they do not recognize the concurrent mode of treatment. So with those patients, it is best practice to provide a one to one treatment with part B patients. If you do have your two patients doing two different activities, you wanna make sure that your documentation is clear to why you are providing a concurrent session. What are you doing in this task and activity that relates to the specific goal, and their plan of care. And you wanna make sure that your tasks that you're giving your patients still meet skill criteria and CMS does not consider performing tasks independently as skilled.

So, just like in all of our documentation, we wanna make sure that what you're documenting shows the reflection of a skilled level of care. So with PDPM, they did present some new rules under group and concurrent, and I'm gonna talk about that, but before we move into that, let's go through group treatment, because the new rules combined group and concurrent under one umbrella. So group therapy is defined as the treatment of two to six patients at the same time who are performing the same or similar activities. Group intervention should, as well, be directed toward a specific goal in each patient's plan of care. Though the goals do not need to be the same or similar for all patients. So CMS notes that each participant in a group treatment must be meaningfully able to participate in the tasks. And again, it must be considered skilled and medically necessary. Just like with concurrent, our documentation needs to reflect our reasons and rationale for selecting this particular mode of treatment. And when you have a group treatment. It's important to document how the group impacted that patient's individual progress and their goals. It's important to consider the reason why you selected that group, and how that group was medically necessary and appropriate

for this particular patient. So let's think about how you can document justification for the use of group, and how it benefited each patient. For example, perhaps there's a psychosocial benefit. Perhaps you're seeing increased participation by your patients due to the group dynamic. These are all very valid and I've personally seen this. So groups definitely can help with our increased participation, psychosocial benefits. It's a great treatment approach. We just need to make sure that we're documenting those reasons why we're doing it, the justification is there, that we're still providing a skilled level of care, and that our group is individually meeting their goals. So again, very important to keep it skilled.

So let's talk about how PDPM has impacted group and concurrent. So as of October 1st, 2019, the patient driven payment model, or PDPM, was put into place. Under PDPM rules, there's a maximum of 25% for both group and concurrent combined for occupational therapy services. So I've laid out an example here of how group and concurrent treatments impact the total amount of minutes given over the course of these four days. So, this is something that you don't need to really worry about because most of our therapy software's are responsible to track the information, but I think it's important for you to know how this impacts your total individual versus group and concurrent minutes, if you're gonna be working in a skilled nursing facility. So you can see there, the first day we've been doing 30 minutes of individual treatment. So that's 100% individual, 0% group, and concurrent combined. The next day we're adding 15 minutes of concurrent, as well as 30 minutes individualized that breaks it down to an 80/20. And then you see on day three, we're adding 30 minutes of group, 15 minutes of individual treatment. Now we've gone above that maximum threshold, now we're at 37% group and concurrent. And then the next day, a 60 minute individual treatment would bring us back down to the allowed 25%. So this is typically something that your manager, or the manager of therapy, is responsible for keeping an eye on and working with you as the OT and the CODA to make sure that you're staying within the guidelines. But the reason why I bring it up is because I do think it's an important

awareness to have as both an evaluator and a treater. And I also think it's important that the therapist always be involved in planning the appropriate groups and concurrent treatments. This way we can assure that that plan of care written by the OT and the groups are designed in a way that we're always rendering out with specific patient goals in mind, which is what our expectations of Medicare are.

Okay, so moving on a little bit from there, let's talk about physician orders and clarification orders. So in order to be considered skilled, first of all, we know we learned in part one that it must be ordered by a physician. And that physician must sign or approve our plan of care. So, if you're new to your skilled nursing facility, it's important to know that process. How are orders received by the physician? How are they communicated to us as a therapist? And then once we write our plan of care, what is the process for getting that physician to sign off on the plan of care? Good questions to ask if you're new to your facility. Now clarification orders. This is technically, they are not a rule per CMS. However, we do see that they are asked of us, quite often, to write clarification orders in the facility. So, if you are being asked to do clarification orders in your facility, I've given you an example here of what would be typical to include in your clarification orders. So that would be your treatment frequency, your duration, and the CPT codes or the names of those codes. So for example, occupational therapy for three weeks, for five times a week for therapeutic activity, self care, and therapeutic exercise. This is just an example. So, if this is something new to you, you might wanna ask at your facility, what are the specifics, and how they like those clarification orders to be written. Standardized test, ot.com has a long list of resources here for us. And I think that standardized tests are extremely important. They really do help to justify our services and really help to paint that picture of progress, and how the patient is doing. So it's my advice to you that if you are new to a skilled nursing facility, you wanna ask you what resources do you have, what tests are available to you in the department, and if there aren't any, then this is a great opportunity to have a conversation with your manager and find out which ones that you could purchase and have available to you.

They really do help us to prove our need for skilled services. And, again, doing these interim reporting is really key, so you can't just do a standardized test at the time of a val You've got to incorporate that in later, whether that's enough progress note, or a 30 day note, recertification. And then again, we wanna make sure we try to capture that before the patient leaves at the time of discharge.

Okay, so we're gonna talk now about daily and progress notes. So just as a key here. Daily notes, you might hear them called treatment encounter notes, it's just another name. You also might hear them called as TENs, so T-E-N, treatment encounter note. I've also been asked what is the difference with a therapy addendum note, because a lot of softwares do offer the addendum note. And typically, that is something that is not tied to billing. So it might be used to document when somebody misses a treatment, so you can explain your reason why they didn't have therapy in a day. Or you could potentially use this area for your S, your subjective part of your SOAP note, because again, it's not tied to any CPT codes. So daily note requirements, typically we have a few things that just our software in general will meet. And that is the requirement to include the date that we provided the services, that includes our signature and our credentials. And typically our billing software captures the time spent in each CPT code and those are things that are required. But typically, we're not entering that into our note because the software usually supports that. But what we do need to be incorporating in, are some of the best practices. So again, I'm just adding that you know these are best practices brought forth by the Medicare guidelines. And you might have more strict guidelines in your facility, so you always wanna follow your company's policy. But again, this is just looking at best practices using our Medicare requirements.

We've learned together that there are a lot of rules around making sure that something is skilled. So we have to use our documentation to prove that what we're providing our patients does in fact meet those requirements, it needs our sophisticated skills, they

need our interventions, and what we're doing is medically necessary and reasonable. And for that reason, that's why I feel, personally, daily notes are a best practice. They give you a chance to paint the picture. So we know we have to break these down, break down our notes by CPT code, we need to support each one of our CPT codes that we're billing in our daily note. The daily notes don't need to be very long, you can keep things brief, and you need to describe what you did that made the activities skilled. You need to describe the patient's response to the activity, and you need to be able to show how you're grading the activity or the skilled interventions that you're providing. And this is my advice, be specific, be specific, be specific. So how do we do that? What do I mean by being specific? We wanna make sure that that documentation shows a progression of our grading of activities. This really does support that our professional clinical reasoning skills and expertise are required. So if we're reading a course of a week or two of your daily notes, I wanna be able to see how you've progressed the activity. If you're starting with one pound weights on day one, I would hope that on day 10, you still wouldn't be on one pound weights. I'd like to see that progression of the activity in your notes.

Second here, describe how the patient's condition impacts the treatment. So a great easy example is COPD patients. Are you monitoring the O2 stats? Are you talking to them about breathing, and how pursed lip breathing might be better for them, or how they can take deeper breaths? All of that makes it skilled. And if you're monitoring their O2 stats, you're definitely giving them more of a skilled service. You wanna document that. Compensatory strategies, therapists, we always do this. We use our words to teach them how to do things in a different way. You wanna document that. You wanna document the education and the instruction you've provided. And you wanna definitely describe the progress the patient is making. And if they're not making progress, you wanna explain why aren't they making progress. What are you doing to change the plan of care because of that lack of progress? And you wanna document any communication, or any consulting that you're providing with other disciplines, nursing

included, and any education that you're providing cross the board. So that education would be from the caregivers to the family members to the patient. Are you adjusting the environment? Are you modifying the task? You wanna document that. Are you providing them any assistive or adaptive devices, anything that you've made for them or got grabbed off the shelf, you wanna make sure you're documenting that. And then again, that objective measurement. We always wanna make sure that somewhere along the line, we're documenting progress in an objective manner.

So, typically our therapy softwares are, have a variety of options of how to write your daily note, and if you've got a lot of pre-filled statements, I would just choose them wisely. If you have the opportunity to have a blank space in your documentation, you can always do a SOAP note in your daily note. So this is a real example here on the left hand side. I actually found this note written by an occupational therapist in an audit I did. She wrote a patient completed green TheraBand exercise. Well, okay, first of all, this is not specific at all. And what did the patient do with the green TheraBand exercise, we don't know. It's not really telling us much about what the patient did, or really at all what we did as an occupational therapist. So what we wanna do is put our perspective, basically, to the focus of what the skilled interventions were that were provided by the therapist, and we wanna be specific. So, in this other example, we have therapists selected green resistive TheraBand and instructed patient to complete two sets of 10 reps for shoulder flexion, shoulder extension, elbow flexion and extension to increase upper body strength needed for functional transfers. Patient tolerated well, required cues for optimal muscle recruitment. So obviously this note gives us a much more clear picture of what the patient was doing, but it also tells us what the skilled interventions were of that therapist, and the reason for that exercise. We also know how the patient tolerated the exercise. It's much clearer. So our weekly end progress note, or weekly or progress note, as it's termed both ways, we wanna make sure that we are framing in everything that we have done during that reporting period. We wanna make sure that we're documenting the skilled interventions that

were provided, and any interim tests that we've done, the results to that. We wanna make sure we're documenting any of that adaptive equipment, orthotics, throughout the course of the reporting period, anything that was issued to the patient. We also wanna give updates, so if there's been a change in medical condition, we wanna make sure we're documenting that. We wanna make sure we're documenting the response to the patients, or the response of the patient to our treatment. And of course, mention any barriers to progress. We wanna make sure we're documenting any programs that were given to this patient or training, anyone, whether it's caregivers, family members, patients, we wanna make sure that's documented in that weekly summary. And our goal performance. So when we're commenting on how the patient is progressing towards goals, we need to be specific. And if they're not making progress, make sure you're documenting why. What was that barrier, and what are you doing because of it?

If a patient has met the goal, this is a good chance for us to determine if the goal should be met, if it should be updated. And we also, as OTRs, wanna make sure if there is no progress, and any goals and a weekly report that we're reassessing and making sure that this is still an appropriate plan of care. We should also be documenting our plan. So what are our recommendations and any rationale that changes, or continuation to the plan of care as we have it established. All right, moving through. Just a couple do's and don'ts. Some of these are just my opinion and I will note that, but let's start with don'ts. So, my opinion is that you should not use the same goals for every patient you evaluate. Medicare does tell us that we need to be specific and individualized. So keep that in mind. You should not use copy and paste features, as again, that does not meet the standards of being individualized. Always, in my opinion, it is appropriate to only use standard abbreviations. So if you're making up abbreviations, or if it's not a standard medical abbreviation, please do not use it. You don't wanna document on hearsay, or opinions, or negativity towards other disciplines. You should not be writing see PT, a val, or see above, or see last progress note, because really that's not what our goals are. I'm sorry that's not what our

documentation should be. We should be documenting on what we do see, and what's in front of us. And this is my opinion because I've actually seen this. I've seen notes that have the exact same word for word on every single note, and that is obviously not what Medicare wants. They want us to be individualized and specific. And to me, that means it would be a different note on each given session. So here's what we should be doing. We should be writing individualized goals. We should be assessing our patients regularly using those approved abbreviations. When in doubt, write it out. We should be documenting any communication with other disciplines. Please use spellcheck. That's my opinion. Please reread your notes, that's my opinion, just to make sure that they sound and they read as what you're want it to say, and we need to be sophisticated.

Just a quick note on discharge summaries. Discharge summaries need to include the date of the initial evaland the date of the final service which typically, our software will do for us, and also a total sessions, again, sometimes in our billing software that will be done for us. We should have a complete summary of all the interventions provided over the course of care. And we should have a summary of how the patient has progressed towards the goals. We wanna be sure to retest any standardized test that we did in the beginning, so that we can have outcome measurements. And we wanna make sure that we have recommendations. So anything that this patient will need beyond today, any follow ups, any referrals, any equipment, we wanna make sure that we're documenting that.

So here are your keys to your documentation success. We wanna make sure we're writing individual goals that we are very clearly defining the potential for each patient. We are documenting the specific response, and the complexity of these services and that's where our sophistication comes into place. That's why cookie cutter notes just don't do it. They just don't give us that sophistication that we need. We wanna make sure we're clearly explaining how our interventions are impacting our patient in front of

us. So how do we do that? Well, here's my advice to you. Keep yourself and your sophisticated skills upfront. So did you change the exercise, say why. Did you adjust the reps, say why. Did you add something new today, say why. Did you grade the activity. Well, describe it, and say why you did. Did you just add something new, say why. And if the patient isn't making progress, say why. Medicare expects us to be sophisticated in our skills. And these are some easy things that we do every single treatment, and we might not be taking credit for them, so don't forget to document so that you can prove what you're doing is in fact skilled.

Okay, so what I wanna do is present to you some ideas of how to do treatments in the SNF. And also, as I talked about in part one, wanted to take some time and review the most common CPT codes that are used in the SNF. So I've combined these two, we're gonna load up our toolboxes, and we're gonna do that based off of each CPT code. We're gonna start with therapeutic exercise. So the CPT code is 97110, and it's defined as objective measurements of loss of strength and range of motion, and effect on function. So the keys with therapeutic exercise is that we wanna be doing them so that we are developing strength endurance, range of motion, and flexibility for our patients. This could be an active, active assisted range of motion. We just wanna make sure that if we're doing range of motion that we're specifying the body part and the plane of movements. We could be doing eccentric movements, concentric movements. We could be establishing a home program. All of that fits under therapeutic exercise. We also have progressive resistance exercises, or PREs. And so what I think is important, whether you're using TheraBand, weights, cuff weights, a bar or putty, is that we wanna make sure that we're defining what muscle group we're working on, and the type of resistance. And if you prefer to work in a plane of movement, so whether you wanna say, biceps and triceps, or if you wanna say elbow flexion and extension, either one is fine, you just wanna make sure that that's included. We wanna be specific to that joint or movement that we're treating, and then be sure you describe what color or what weight the patient is using, so that you can then show

a graded activity throughout the course of your treatments, and show progress. Therapeutic exercise also includes techniques to increase the flexibility of range emotions. So an example of that might be a contract, relax technique, stretching, core exercises, core strengthening can fall into therapeutic exercise. Just make sure you're describing that plane of movement, and if you're using resistance. So you could do bands, or you could do a weighted ball. We also have our open and closed kinetic chain exercises, isokinetic exercises. Again, just making sure you're describing that plane of movement, or the joints involved. And what I think is key with therapeutic exercise is monitoring vitals, really does help to keep it skilled, whether you're doing heart rate, or pulse ox, perceived exertion is a great way to document how the patient is tolerating the exercise in front of them. Documentation for Therax, you wanna make sure you're specific. You wanna make sure that every exercise has purpose and relates somehow to function. You wanna make sure that you're documenting your instructions given, and any assistance that you've provided the patient. Again we're trying to make sure that we're demonstrating that the skills of the therapist were in fact required.

So self care, I think as OTS, this is our, obviously, our most important area to address. So 97535, it is defined as objective measurements of the patient's activity of daily living, instrumental activity of daily living, and then impairment in that area. So this includes participation in ADLs, teaching them compensatory training, meal prep, safety procedures, working on assistive technology devices, adaptive equipment, energy conservation techniques, fine motor, gross motor skills all in relation to ADL, cuing for your task initiation, progressions, sequencing, safety, problem solving. Again, with the CPT code, it's important that we don't forget to document all of our cues, because that really is a big part of how we can bill this particular code. So, obviously, we can use this code as we facilitate in a variety of activities and tasks. I think it's just really important to keep in mind the specific compensatory training provided, making sure that you're documenting what areas, as an OT, we're helping them with safety, or the adaptive equipment, or the assistive technology, or the compensatory strategy, all of

that needs to be documented. And you wanna also make sure that you're documenting the instruction given, it's extremely important. So there's a lot of ways that we can incorporate ADL, postural alignment, balance, crossing midline, segmental rotation, trunk mobility, righting reactions, weight shifting. And of course in our IADL. As I mentioned earlier, I think that IADL is an area we definitely can work in the skilled nursing facility. So, using a walker in a small space. Perhaps doing a light meal prep. And if you don't have a stove or microwave, you can always do a cold meal prep, or simulation, if needed. I like the activity of using hangers on a rod, because you could have them gather clothes, reach them up higher. You could even have them pick up clothes from a basket on the ground, so that you're having them do a low to high activity. We do this a lot with just carrying items with use of a walker. I think that's a great area for OT to focus in on. And then same thing with laundry. If you don't have a washer and dryer at your facility, you can always simulate it. Making sure that they're going to be safe to be able to do that task at home.

Therapeutic activity, probably one of the most common areas used in the SNF, 97530, defined as the use of dynamic activities to improve functional performance. So there's a lot of areas that can fall into the CPT code. I'm gonna just try to highlight some areas. So graded physical assist for activities, of course, can be used for transfers and for bed mobility. Weight bearing activities, weight shifting activities, righting reactions, postural control, trunk alignment. Some of my favorite therapy activities is to use a mirror in front the a patient, and this way you can see if they can respond to your tactile cues. You can give them lateral shifting cues, see if they can stay centered in the mirror. You could do some activities with them reaching for forward flexion, or you could even provide assistance, or sorry, resistance into forward flexion and extension to help build some of their trunk strength. You could have them reaching across the midline. In our clinics, we do a lot of low to high activities, so maybe putting a bucket of rings or clothes pins, something down at their feet, having them reach it up higher, perhaps to, above shoulder level, but at least a shoulder level to get them to do more

of a dynamic seated activity. Therapeutic activity also falls into instruction and compensatory strategies during sitting, standing transfers. So you can use your skilled and sophisticated techniques to help them with their body awareness and make sure that they're not neglecting, perhaps, one side or the other. We can use our techniques to reduce their pain, to improve any sensory loss, or to work on their visual field or visual perceptual compensatory techniques. Therapeutic activity also does involve eye hand coordination, gross motor tasks, grasp and release. Again, the list does go on and on with therapeutic activity.

So let's just focus in on our documentation. Where should we be? Well, we wanna make sure that we're documenting our specific activities performed and what made it skilled. So what was the amount and type of assistance that we provided, the type of cues we provided, perhaps that's a physical cue, maybe it's a verbal cue, maybe it's a strategic cue. We wanna make sure that everything that we're doing as therapists is included into that note. So don't forget, compensatory strategies are something we constantly are giving our patients. Don't forget to document that. Let's prove that the skills of a therapist were needed. Wheelchair management, as I mentioned last time, is an area where OTs definitely have an opportunity in the skilled nursing facility. So this is 97542, wheelchair management, and it's defined as the assessment or modification of current seating system, positioning in new or existing wheelchair seating system, or positioning techniques to reduce subluxation, inhibiting abnormal reflexes or synergies, promoting proximal stability, or distal control for object manipulation and reducing edema, pain, or pressure. So what I think is important with this particular CPT code is that we make sure that we are documenting any functional deficits due to poor seating or due to poor positioning duty. What can't our patient do? How does our interventions help them to be more functional? Another good idea is to make sure that you've documented any outside strategies or interventions that nursing has tried, caregivers have tried that have failed. And that has really prompted us to get involved. We also

wanna make sure that when we use the CPT code, that we relate our goals to function, and make sure that that's attainable for the patient or caregiver.

So a couple other keys on wheelchair management. This could be various adaptions trialed and how the patient is responding to those interventions. So you wanna make sure that you're documenting that. Perhaps you're using wheelchair management to get the patient to do better with wheelchair propulsion, that's appropriate under the CPT code, as well as making sure the patient is safe with the use of a wheelchair, that they can get around in that environment, making sure that they're scanning, they can do their turns, they can lock their wheelchair. all of this is important with the CPT code. Also, you wanna make sure if you're documenting in the CPT code that you include any loss of range of motion, any impaired strength, impaired balance, if there's any skin integrity issues, or sensation issues, you wanna make sure that that's included in your notes, as well as any tone issues. All of that helps to make sure that we're meeting skilled requirements.

So neuromuscular re-education, 97112, is defined as the objective loss of ADLs, mobility, balance, coordination deficits, hypo or hypertonicity, posture, and effect on function. This includes activities with balance, coordination, proprioception, and when billed for treatment for balance dysfunction, you always wanna make sure that the impairments are stated and relate to a functional component as we've mentioned. So examples of this would be, perhaps you're working on treating nerve palsy. So you might be doing a vibration to stimulate the muscle, or you might be working on decreasing tone of an area of hypertonicity. You might be using this code with a patient with muscular weakness due to a spinal cord injury, and you're working on their proprioceptive skills with a postural activity. You could use this code when you're working in sitting balance, providing cues for muscle recruitment. This code is also used with PNF exercises. So NDT activities, if you're familiar with these, this would be an appropriate CPT code to use those interventions. The key here is to remember that

with the CPT code, we're facilitating re-education of movement, of balance, of posture, of coordination, and of proprioception. Those are the keys with neuro re-ed. So activities can include righting reactions. If you are doing protective response or protective extension, righting reactions, you just wanna document if it's absent, present, or present but delayed. You can also use this code when you're performing standardized tests like the Berg, the Tinetti, the functional reach. And here are your cues for documentation. Making sure you're documenting the loss of balance and which direction, how much assist is needed, and then what strategies are they using to regain their balance. And the grading for this should be used, normal, good, fair, poor. You wanna make sure you're documenting if it's either static or dynamic, and whether it's sitting or standing. It's important to document the specific activities performed and again, progression of those activities throughout the course of your treatment. And don't forget these purposes of these activities as it relates to function helps to support that the skills of the occupational therapist were needed.

So in January of 2020, the American Medical Association created two new CPT codes for cognitive intervention. So 97129 is for the initial 15 minutes of working on cognitive function. So that would include our activities for attention and memory, and reasoning, and executive functioning, problem solving. And the second, or each additional 15 minutes, would be coded under 97130. So we just wanna make sure, again with, like we talked about with PT and duplication of services, you wanna make sure you know if speech is involved, and if they are, what are they treating the patient for. And just be sure that we're not overlapping or duplicating services when you're using this code or this treatment approach. So the goal of the medical record is to reflect the needs of the patient. So we've discussed this today. We need to paint the clinical picture of our patient. The medical record also needs to justify the skilled services and the CPT codes that were billed. So as you document your CPT codes, remember that this is where your sophisticated skills need to shine. Your interventions, your cues, your compensatory strategies, the education you're providing, all of this needs to be

documented. And don't forget to be specific, Medicare is expecting us that we're being individualized and specific to justify skilled services.

And finally, it is expected that the medical record provides important communication amongst team members. And this should include the development and course and outcomes of our interventions, our assessments, our observations, our treatment, and our trainings. So we wanna make sure it's collaborative. And Medicare does expect that we're working with our other team members and collaborating with them. So I do hope that this course has made you feel ready to treat and document as an occupational therapist in the skilled nursing facility. And before I wrap up, I just wanted to wish all of the occupational therapists a happy OT month since it is April. And thank you for your dedication to our patients and to this industry. I hope that you've enjoyed learning about OT in the skilled nursing facility setting. And if you do have any further questions, don't hesitate to reach out. I'm happy to be a resource for you. And with that, that does end our presentation. I gave you some acronyms that I use throughout the presentation, and you have that in your handout as well. So I think at this time we could open it up if there are any questions.

- [Fawn] Thank you, Kathleen for a great talk. Yes, there are some questions coming in, so let us bring those up here. First, there was some clarification. Someone was asking why are we no longer allowed to bill CPT therapeutic activity on evaluation when billing evaluation. Sorry I kind of messed that up a little bit, but do you understand what I'm asking?

- [Kathleen] I do and I think that would be going back to modifiers and I didn't wanna get into the depth of modifiers 'cause there are a lot, but I do believe that that was something that they pulled back on. I would need to reference that. However, what we wanna know about billing in the skilled nursing facility is that there are certain codes that they don't feel we can do at the same time. So, there were some that came out

this year, unexpectedly, none of us even knew that they were making these changes, and they said you can't bill the eval and certain CPT codes. So, the reason why they do that is because of just they think that those two things cannot be done at the same time. But that's part of the reason why we need to make sure we're being very clear in documenting and drawing the line in the sand. So, I'm not prepared to answer it as far as the details of what codes can't be billed together, but typically your therapy software is going to give you that heads up that you can't do it. So, reasons are because they think we can't do the two codes at the same time. What you need to make sure that you do is document clearly, of what you were doing for that individual CPT code. I'll tell you when a lot of evaluations I'll see no documentation of CPT codes for treatment. And I think that that's where we've gotten ourselves into some difficulty with CMS is 'cause we're not being clear, and saying this was an eval code, this was a treatment code. So we just need to clean that up. We could do modifiers in another presentation.

- [Fawn] All right, thanks for the clarification. Another question coming in is on evaluation day, do you have to write a TENs note if you bill for treatment, or is it okay if you put everything in evaluation, which you might have just answered this.

- [Kathleen] I did and I think that's a really good point, again, we have to document that CPT code separately if you are billing for it separately. And part of the reason why we have these modifiers is because we haven't been doing a great job there.

- [Fawn] Very good, thank you. Another question, does CMS require at least one long term goal to be from a standardized test, is this best practice?

- [Kathleen] So no, they actually don't have any language that tells us we have to be doing a goal with a standardized test. And I've had a lot of dialogue with my colleagues around this. So, standardized tests should be in your evaluation and they should be

clearly documented. And that we do know for a fact. However, you do not, there is no requirement that says you have to write a goal around a standardized test. So my advice to you is that you keep your goals function based, but you do clearly document in your progress section, how that patient is doing from a standardized test that you did on a eval throughout your documentation, whether that's in a progress note or in a monthly note, or in your discharge summary.

- [Fawn] Okay, great. Is there a difference in CPT codes for cognition.

- [Kathleen] So that was the last, the last update we had on cognition is that 97129, I believe. I'm coming off of memory here. That is a new code as of January. So if you're not familiar with CPT code 97129, that is the code now to focus in on cognitive function for OTs. So that addresses all of our areas, whether it's doing compensatory strategies, or you're working on memory or attention, executive functioning, as of January, that is the cognitive code for us now.

- [Fawn] Okay, another question, my facility has many residents with high levels spinal cord injury or MS. Sometimes I feel that our goals may not focus on function but are needed. Examples would be splinting, or pass a range of motion to improve skin integrity and prevent contractures. What do you suggest in these situations?

- [Kathleen] And that's a great question, and I'm glad you brought that up because you're right. Not all of our patients can really make huge leaps and bounds and changes of functions, specifically in that narrow population. So I think what you're doing is right. You're breaking it down into something that is meaningful, and that is skillful. So, writing a goal to reduce their contractures, to reduce their risk for skin breakdown, skin integrity, that is all skillful. So some of the areas that you want to just focus on, are anything objective that you can do. So in that splinting program, maybe you could do some objective measurements of their contractures. So doing a range of

motion objective measurements from pre-splint to post splint. You also can you know do skin integrity documentation. How long are they able to tolerate that splint. For this particular patient we're not gonna see the leaps and bounds in function. And it just goes back to those two requirements to be medically necessary and reasonable. What are you doing as the occupational therapist that no one else can do? And splinting definitely falls into that. I would just suggest that you be careful with how long you're treating the patient. Your duration and frequency need to match that. So for a particular goal of just splinting, if that's the only thing in your plan of care, we would expect that your duration and your frequency would match that. You wouldn't wanna be seeing the patient seven days a week for 60 minutes, just as a extreme example. But that's what I would keep in mind when you're having those more of component based goals, rather than true big functional goals changes.

- [Fawn] Okay, we have one more comment and one more question, and then we'll wrap up. She responded back about the cognitive goals. They were 97129 and 97130.

- [Kathleen] Correct, so the 97130 is that 15 minutes, additional from the first 15 minutes.

- [Fawn] Okay, and then here's the last question, and then we can wrap up. Any suggestions and how and when to complete this documentation? =[Kathleen] Great question. I think we've all moved into the technology age where most of us are documenting now on either a laptop or tablet, and I think that we need to adjust with the time. So I started back when it was pen and paper, but like everybody else I've moved into the technology age. So my advice to you as a registered occupational therapist is that I hope that you can have a laptop. I think that that is the best way to get your documentation done with the patient. We have done studies that the documentation you do alongside your patient actually is better. It's more specific, it's more individualized than the documentation that's done at the end of the day in the

office. So my hopes is that your company would provide you with a laptop that you can take it with you and do point of service documentation. And as we treat and for the assistants, I think that it's important to have a tablet, or if available, a laptop as well. I do recommend that the point of service, again, is the best way to really capture the individual and specific needs of our patients. I truly think you're going to do a much better job with being more individualized and more specific when you are documenting with the patient. And it's great that if you can even include in that SOAP, or in that S part, subjective part, the patient's response to treatment, even patients' comments. That is a great way of showing that we are really incorporating our individual patient's needs and their response to our treatment. So that's my recommendation. I know that might not be the case in every facility everywhere, but I hope that we can move to that one to one ratio of therapist to laptop or device.

- [Fawn] Great, thank you so much. And great for, excuse me, thank you so much for the great Q and A session today. I hope everyone has a great rest of the day. You join us again on continued and occupationaltherapy.com, thanks everyone.